County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

December 14, 2010

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL OF LACERA MEDICARE PART B PREMIUM REIMBURSEMENT PROGRAM FOR 2011 (ALL DISTRICTS) (3-VOTES)

SUBJECT

Recommendation to approve County reimbursement of retiree Medicare Part B premiums for retirees who are enrolled in a Los Angeles County Employees Retirement Association (LACERA) administered Medicare Risk HMO or Medicare Supplement Plan in 2011.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Renew for the 2011 calendar year, County reimbursement of Medicare Part B premiums for retirees who are enrolled in a LACERA administered Medicare Risk HMO or Medicare Supplement Plan. Beginning January 1, 2007, Medicare instituted a means test that imposes additional Part B premiums on higher income individuals. This recommendation does not intend that the County reimburse any additional costs for persons affected by the means test.

2. Instruct the Chief Executive Officer to report back to your Board prior to January 1, 2012 with recommendations regarding Part B reimbursement policy for the 2012 calendar year.

3. Reaffirm your Board's right to change or terminate the Medicare Part B premium reimbursement program at any time if it ceases to be cost effective.

PURPOSE/JUSTIFICATION OF THE RECOMMENDED ACTION

Since 1992, the County has sponsored retiree health insurance plans designed to encourage retirees to fully participate in the Federal Medicare program. This has included reimbursing retirees for the cost of participating in Medicare Part B in those instances where the retiree has enrolled in one of the Medicare Risk HMOs or the Medicare Supplement Plan administered by LACERA. By prior Board direction, reimbursing retirees for the cost of Medicare Part B requires an annual determination that the program remain cost effective. The purpose of the recommended action is to affirm that such determination has been made and to obtain your Board's authorization to continue the program through calendar year 2011.

Reimbursing retirees for participation in Medicare Part B is necessary in the absence of a policy requiring participation. Mandatory participation is one among many topics we plan to discuss with LACERA as a means of reducing future health care costs.

Background

The County contributes an amount equal to a percentage of the health care plan premium or the benchmark Anthem Blue Cross I and II indemnity medical plans. For members with 10 years of service credit, the County contributes 40 percent of the health care plan premium or 40 percent of the benchmark plan rate (Anthem Blue Cross Plans I and II) whichever is less.

For each year of eligible retirement service credit beyond 10 years, the County contributes an additional 4 percent per year of the health care plan premium or 4 percent of the benchmark plan rate (Anthem Blue Cross Plans I and II) whichever is less, up to a maximum of 100 percent for a member with 25 years of eligible service credit.

The menu of County sponsored LACERA administered retiree health plans includes Medicare Risk HMOs and a Medicare Supplement Plan. A Medicare Risk HMO is an HMO in which participants have assigned over all rights to Medicare Parts A and B to the HMO. The participant effectively agrees to receive all of his or her medical care from the HMO and to waive any right to use Medicare benefits outside the HMO. In exchange, Medicare agrees to pay the HMO a monthly "capitation" fee on behalf of the participant. That fee defrays much of the cost of the HMO coverage. The reduction in cost is passed on to the retirees and the County in the form of lower premiums and lower County subsidies.

A Medicare Supplement Plan is an indemnity plan that complements Medicare benefits. Medicare becomes the primary payer, meaning Medicare pays first on each claim. A Medicare Supplement Plan essentially picks up where Medicare leaves off within the limitations set forth by Medicare.

LACERA currently administers three Medicare Risk HMOs and one Medicare Supplement Plan. The HMOs are "Kaiser Senior Advantage," "SCAN," and "PacifiCare/Secure Horizons." The Medicare Supplement Plan is "Anthem Blue Cross III." There are an estimated 28,300 County retirees enrolled in these plans (including dependents).

Medicare Parts A and B

The Medicare Risk HMOs and the Medicare Supplement Plan require the eligible retirees to be enrolled in Medicare Parts A and B. Part A covers hospitalization costs and Part B covers physician services and other ancillary items such as laboratory testing and durable medical equipment. Part A coverage is earned by working the required Social Security quarters and Part B must be purchased by eligible participants.

For 2010, a Hold Harmless provision in the Social Security laws keep the Part B premium flat for those who have Part B premiums deducted from their Social Security checks. Those that did not have Part B taken from their Social Security checks, as well as new entrants to Medicare, had their Part B premiums increase to $110.50. For 2011, Medicare Part B premiums will be the same $96.40, or $110.50 for those that have Part B taken from their Social Security checks. For all others, the Standard Medicare premium will go up to $115.40 per month (an increase of 4.4 percent).

With the Hold Harmless provision again applying, existing retirees who have Part B withheld from their Social Security will continue to pay the amounts they do currently, while the new entrants to Medicare in 2011 and those who do not have their Part B withheld from their Social Security will pay the $115.40. The County covers the standard Part B premium for retirees and dependent participants in the Medicare HMOs and Medicare Supplement plan.

Income-Related Medicare Part B Premium

As part of the Medicare Modernization Act, effective January 2007, Medicare Part B premiums are now income or means tested. Medicare means testing imposes higher Part B premiums on higher income people on a graduated basis beginning with retirement incomes over $85,000 per annum.

The standard Part B premium does not apply to individuals subject to the means testing, therefore, they are required to pay the higher Part B standard premium plus the means tested amount taking effect on January 1, 2011. Under the County's current Part B reimbursement policy, only the standard Part B premiums are reimbursed. We are recommending no change in that policy.

Annual Re-evaluation Is Necessary

The decision to pick-up Medicare Part B premiums is essentially an annual determination that considers, among other things, changes to the Part B program and premium costs. From the inception of the Part B reimbursement program in 1992, the County has reimbursed the full cost of the standard Part B premium for any retiree who has enrolled in a Medicare Risk HMO and the Medicare Supplement Plan. The justification advanced to your Board in 1992, and we believe is still valid today, validates that the cost of the Part B coverage is more than offset by the reduction in premiums for the Medicare Part B program.

The 1992 Board action originally provided for reimbursement of the Part B premium through 1995. This included any late enrollment penalties imposed by Medicare for retirees who enrolled prior to May 1993. The 1992 Board action also provided for an annual cost justification from 1996 forward. Under the original authorization, the program is subject to change or cancellation at the discretion of the Board. It may be continued only "if cost savings are realized." That requirement has been reaffirmed in all subsequent Board authorizations of this program and should be considered reaffirmed in these recommendations as well.

Recommended Pick-Up of January 1, 2011 Part B Premium

The additional County cost of picking up the basic 2011 Part B premium would cost an additional $3.0 million per annum for a total of $37 million per annum (all funds). The key question at this point is whether spending this amount will save more than it costs. In other words, is spending $37 million prudent to retain the current level of participation in the Medicare Risk HMOs or the Medicare Supplement Plan, and thereby avoiding more than $37 million in higher subsidy costs that could be caused by a possible reverse migration out of these plans? We believe it is.

Eliminating the Part B reimbursement would likely cause a majority of the participants in the Part B Reimbursement program to change their current coverage in favor of higher cost LACERA plans. Of the estimated 28,300 eligible participants currently in the program, approximately 14,300 are receiving a 100 percent County subsidy because

they have 25 or more years of County service. These individuals could enroll in almost any LACERA health plan and have the full premium paid by the County up to the aforementioned maximum subsidy limit established by the Anthem Blue Cross I and II Plans. They could do this with no obligation to purchase Part B coverage.

Although there is no way to be certain what the costs of the retiree health insurance program would be in the absence of this incentive, Buck Consultants, an independent actuarial consulting firm, believes the likely impact on either eliminating the Part B reimbursement program or freezing the level of reimbursement at the 2010 levels would be an increase in overall County costs ranging from approximately $26.5 million to $52.8 million per annum. This would be in addition to the projected annual expenditures of $37 million estimated for 2011. A copy of Buck Consultant's analysis is included in Attachment I.

LACERA independently employed the firm of Mercer to review this issue. Mercer concurs that overall County costs for retiree health care would be dramatically higher in the absence of the Part B reimbursement program. A copy of Mercer's analysis is included in Attachment II.

Attachments III through VIII provide additional information on the difference in current retiree costs and benefit coverage between the Kaiser Senior Advantage and Anthem Blue Cross III plans, and the alternative non-Medicare related Kaiser Excess I, and Anthem Blue Cross I and II Plans. The populations in Kaiser Senior Advantage and Anthem Blue Cross III represent approximately 87 percent of the total Part B reimbursement program participants.

IMPLEMENTATION OF STRATEGIC PLAN GOALS

The recommended action supports the County's Strategic Plan Goal of fiscal responsibility.

FISCAL IMPACT

The recommended action would result in additional Part B reimbursement costs of approximately $3.0 million per annum (all funds). However, the costs of not approving the recommendation could be much greater.

FACTS AND PROVISIONS

The recommended continuance of the Part B reimbursement would take effect on January 1, 2011, and be initially reflected in LACERA retiree warrants issued on December 31, 2010.

The amount reimbursed will include any late enrollment penalties paid by retirees who enrolled during the special open enrollment period prior to May 1993.

The Chief Executive Officer will report back prior to January 1, 2012 with additional recommendations relating to Part B reimbursement policy for the 2012 calendar year.

Respectfully submitted,

WILLIAM T FUJIOKA
Chief Executive Officer

WTF:BC:JA
MTK:WW:mst
Attachments (8)

c: Los Angeles County Employees Retirement Association
Auditor-Controller
County Counsel

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ATTACHMENT I

buckconsultants® A Xerox Company

November 16, 2010

Mr. Wayne Willard
County of Los Angeles
Chief Administrative Office
526 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Re: Expected Impact of Modifying the Part B Reimbursement for Retirees

Dear Wayne:

This letter presents Buck Consultants LLC's (Buck) analysis of the expected cost impact of modifying the current County practice of reimbursing retirees and their dependents for the Medicare Part B premium. This encourages retirees to enroll in the Blue Cross III Medicare Supplement Plan or in one of the Medicare plans offered by the HMO plans.

Based on our analysis, we believe that it is in the County's interest to continue the current program to reimburse retirees for their basic Part B premium but not to cover the additional means tested Part B premium that became effective January 2007. This means that the County would not pay for the additional means tested amount that Medicare will charge to high income participants. Deciding not to pay the Part B premium would cost the County between $26.5 and $52.8 million for 2011.

Under our analysis, we developed the expected cost impact to the County under two scenarios. In the first, the County elects to freeze the Medicare Part B reimbursement at the current level ($96.40 per month for those who reached Medicare eligibility in 2009 and pay the premium through their Social Security check or earlier, $110.50 for all other Medicare eligible retirees). In the second, the County elects to suspend the reimbursement of the Part B premium in total. In both scenarios, we have assumed that the County will not cover the additional means tested Part B premium that became effective January 2007.

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619.725.1700 • 619.297.5220 fax

In our analysis, we have assumed that LACERA will still elect to offer the Blue Cross Plan III and the various Medicare Advantage plans regardless of whether or not the County elects to continue to pay the Part B premiums. This decision is to the financial advantage of the retirees, particularly to those with less than 25 years of service at retirement.

For example, a retiree who is Medicare Eligible and has 15 years of service at retirement pays a monthly premium of $118.72 under the Blue Cross Plan III, but would pay $365.72 under the Blue Cross Plan II, or an increase of $247.00 per month. Even if this individual had to pay the 2010 Part B premium of $96.40 or $110.50 (depending on the circumstances) he would still pay either $150.60 or $136.50 less per month by remaining in the Blue Cross Plan III, or a savings of between $1,638.00 and $1,807.20 per year as compared to dropping Part B coverage and electing the Blue Cross Plan II.

Of the approximately 24,000 participants in a Medicare Advantage or the Blue Cross III plan, 9,800 have less than 25 years of service and as such are paying some of the cost of the medical plan they elect. Keeping these plans in place for these members makes financial sense for the County and the retired members.

In developing our analysis, we focused strictly on these 24,000 participants. In the first scenario, we assumed that the County freezes the Medicare Part B reimbursement at the current premium amount of $94.60 or $110.50 per month. In addition, for those individual who are paying a penalty for late enrollment, the penalty reimbursement remains frozen at the amount of penalty reimbursed in 2010. Based on the current average monthly reimbursement of $127 per retired participant, the expected reimbursement for 2011 would be $127 if the County continued its current practice. Freezing the contributions at the current levels means that on average retirees would pay between $0 and $4.90 per month in Part B premiums, depending on whether their Part B premiums are frozen at current levels.

In determining whether a retiree would elect to pay the additional Part B premium and remain in the current Blue Cross III or Medicare Advantage plan, we compared the difference in premium paid by the retiree for their current plan plus the additional Part B premium to the medical premium payment for a non-Medicare Plan. For this analysis, individuals in the Blue Cross III and SCAN HMO plans were compared to the Blue Cross II plan and those in CIGNA, Kaiser, and PacifiCare were compared to the available non-Medicare option for the particular HMO.

We then developed the cost impact of three election alternatives:

- Maximum cost impact – if the retiree cost of the current medical plan plus the additional Part B premium is less than the cost of the applicable non-Medicare plan, the retiree remains in their current plan. If the retiree cost of the current medical plan plus the additional Part B premium is greater than or equal to the cost of the applicable non-Medicare plan, the retiree moves to the non-Medicare plan.

- Minimum cost impact – the additional per month average Part B payment does not cause any movement in plans; retirees remain in their current plans.

- Expected cost impact – this represents our expected outcome. For those where the retiree cost of the current medical plan plus the additional Part B premium is less than the cost of the applicable non-Medicare plan, the retiree remains in their current plan. If the retiree cost of the current medical plan plus the additional Part B premium is greater than or equal to the cost of the applicable non-Medicare plan, then 50% of the retirees move to the non-Medicare plan and the other 50% remain in their current plans.

In the first scenario, the cost impact to the County ranges from an additional $106 million under the maximum cost impact scenario, a savings of $0 under the minimal cost impact and a cost of $53 million under the expected cost scenario. In the second scenario, we assumed that the County elects to suspend the reimbursement of the Part B premium in total. This means that on average, the retirees would have to pay an additional $127 per month in Part B premiums and penalties to remain in their current plans.

In determining whether a retiree would elect to pay the additional Part B premium and remain in the current Blue Cross III or Medicare Advantage plan, we compared the difference in premium paid by the retiree for their current plan plus the additional Part B premium to the medical premium payment for a non-Medicare Plan. Individuals in the Blue Cross III and SCAN HMO plans were compared to the Blue Cross II plan and those in CIGNA, Kaiser, and PacifiCare were compared to the available non-Medicare option for the particular HMO. We then developed the cost impact of the same three election alternatives as in the first scenario.

In the second scenario, the cost impact to the County ranges from an additional $90 million under the maximum cost impact scenario, a savings of $37 million under the minimal cost impact and a cost of $27 million under the expected cost scenario. The cost is less under this scenario because the County is no longer paying the Part B premium amounts. The attached exhibit summarizes the results of our analysis for both scenarios.

After your review, if you have any questions or comments, please give me a call and we can discuss.

Sincerely,

Michael W. Schionning, F.S.A., M.A.A.A.
Principal & Consulting Actuary

Exhibit I

County of Los Angeles
Cost Impact of Modifying the Part B Reimbursement Policy
Medicare Eligible Participants Only
Calendar Year 2011

		Scenario 1 - Freeze at 2010 Levels			*Scenario 2 - No Part B Reimbursement*		
	Current	Maximum	Minimum	Expected	Maximum	Minimum	Expected
Blue Cross	$41,399,274	$79,124,195	$41,399,274	$60,261,734	$74,099,565	$27,319,459	$50,709,512
CIGNA	$324,604	$324,604	$324,604	$324,604	$275,604	$275,604	$275,604
Kaiser	$45,429,267	$102,606,640	$45,429,267	$74,017,953	$94,332,558	$27,368,210	$60,850,384
SCAN	$1,747,168	$3,370,013	$1,747,168	$2,558,590	$2,932,880	$929,482	$1,931,181
PacifiCare	$12,078,902	$21,112,163	$12,078,902	$16,595,533	$19,376,392	$8,143,597	$13,759,995
Total	$100,979,214	$206,537,615	$100,979,214	$153,758,414	$191,016,999	$64,036,352	$127,526,676
Cost/(Savings)		$105,558,401	$0	$52,779,200	$90,037,785	($36,942,862)	$26,547,462

E. Clayton Levister III
Principal

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MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

ATTACHMENT II

November 10, 2010

Ms. Cassandra Smith
Director Health Care Benefits Program
LACERA
300 N. Lake Ave, Suite 300
Pasadena, CA 91101

Subject: Medicare Risk Savings Projections

Dear Cassandra:

Attached are the Medicare Risk savings projections to evaluate the 2010/2011 cost effectiveness of the County offering Medicare Risk plans and subsidizing Medicare Part B premiums for LACERA retirees and dependents enrolling in those plans.

For 2010, a Hold Harmless provision in the Social Security (SS) laws keeps the Part B premium flat for those who have Part B premiums deducted from their SS checks. Those that did not have Part B taken from their SS checks, as well as new entrants to Medicare had their Part B premium increase to $110.50. For 2011 Medicare Part B premiums will be the same $96.40 or $110.50 for those that have Part B taken from their SS checks. For all others, the Standard Medicare premium will go up to $115.40 per month.

Because LACERA has a number of health plan options, we have included four "migration scenarios" for each analysis. Each has a different set of assumptions of where the retirees might enroll if the County did not offer Medicare Risk plans and subsidize Medicare Part B premiums for enrollees who participate in those plans.

Under all analyses and scenarios, it is in the County's financial interest to continue offering Medicare Risk plans and subsidizing Part B premiums for enrollees in those plans.

Background about the Part B Premium

Medicare Part B Premium

The Medicare Part B premium as of January 1, 2010, was $96.40 for those that have Part B taken from their SS checks and $110.50 for all others and new entrants to Medicare. For January 1, 2011, there is an increase to the standard Part B premium level to $115.40. With the Hold Harmless provision again applying, existing Retirees who have Part B withheld

from their SS will continue to pay the amounts they do currently, while new entrants to Medicare in 2011 and those who do not have their Part B withheld will pay the $115.40.

The County covers the Part B premium for retiree and dependent participants in the Medicare Risk HMOs and Plan III. There are approximately 23,000 retirees in such plans. According to the Medicare Part B Reimbursement and Penalty Report for the pay period 09/30/2010, the average amount paid for retirees, dependents and penalties is approximately $127.05 per retiree.

Income-Related Medicare Part B Premium

As part of the Medicare Modernization Act, effective January 2007, Medicare Part B premiums will be income tested. Currently, the Medicare Part B premium is set at 50% of the monthly actuarial rate (MAR). The MAR represents 50% of the cost of Part B benefits. Therefore, the standard Medicare Part B premiums cover about 25% of the cost for Part B expenditures. Effective January 2007, individuals over a certain income level will pay more than the 25% target premium. Our model assumes that the County will not reimburse the means-tested amounts of the Part B premiums. It also assumes that the County will pay only for the standard Medicare Part B premium (amounts which depend on what year the retiree became eligible for Medicare) and the late penalties for those who enrolled when the reimbursement plan was first introduced.

Projection Methodology

In this projection, the savings is determined by comparing LACERA's current total plan cost (medical, dental, and Part B premium) with the projected total cost if there were no Medicare Risk plan offerings. The projected costs are based upon migration of Risk participants into non-Risk plans and the removal of the Part B premium. The County's contributions are based upon years of service. For the 2010/2011 policy period, we estimate them to be 90.75% of the total cost. This factor is applied to the premium to split the County and retiree portions.

Projection A – Migration Assumptions

This projection assumes that all Medicare HMO Risk participants move from their current HMO Risk plan into the corresponding HMO's non-Risk plan; that the Kaiser Senior Advantage participants migrate to the Kaiser Excess plan; and that the Scan and Plan III participants migrate to Plan II. In addition, Projection A assumes that the County will stop paying the Part B premium for all members. Under this scenario LACERA will have saved approximately $161.38 million in total medical cost.

Projection B – Migration Assumptions

This projection assumes that all Medicare HMO Risk participants migrate from their current HMO Risk plans to Plan II; that Plan III enrollment remains unchanged; and that the County will continue to pay the Part B premium for Plan III participants. Under this scenario LACERA will have saved approximately $105.45 million in total medical cost.

Projection C – Migration Assumptions

This projection assumes that the Medicare HMO Risk participant migration is split 50/50 between Plan II and Plan III; that Plan III enrollment remains unchanged; and that the County will continue to pay the Part B premium for Plan III participants. Under this scenario LACERA will have saved approximately $57.32 million in total medical cost.

Projection D – Migration Assumptions

This projection assumes that the Medicare HMO Risk and Plan III participants migrate to Plan II, and that the County will stop paying the Part B premium for all members. Under this scenario LACERA will have saved approximately $170.15 million in total medical cost

Summary of Findings

Based upon our analysis, there continues to be savings from the Part B reimbursement programs and having Medicare eligible members enroll in Medicare HMO's or plan III.

Pease call me at (213) 346-2539 if you have any questions or would like to discuss any of these projections.

Sincerely,

E. Clayton Levister III
Principal

Copy:
Laurie Silva - Mercer

Attachments:
- Migration assumptions
- GRIST New Medicare Part B, deductibles, Coinsurance 2011

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Los Angeles County Employees Retirement Association
Medicare Risk - Medicare Supplemental - Prudent Buyer
Premium Projections as of July 1, 2010
All Carriers Combined

	July 1, 2010 through June 30, 2011			
	Migration A	**Migration B**	**Migration C**	**Migration D**
Current Plan Cost (w/Part B Subsidy)				
County Share	$392,578,140	$392,578,140	$392,578,140	$392,578,140
Member Share	$40,010,893	$40,010,893	$40,010,893	$40,010,893
Total	$432,589,033	$432,589,033	$432,589,033	$432,589,033
Assumed Plan Cost (w/Migration and Benefit Options)				
County Share	$553,963,051	$498,023,407	$449,899,356	$562,727,233
Member Share	$56,458,967	$50,757,694	$45,852,973	$57,352,197
Total	$610,422,018	$548,781,101	$495,752,329	$620,079,431
Annual Cost / (Savings)				
County Share	-$161,384,911	-$105,445,267	-$57,321,215	-$170,149,093
Member Share	-$16,448,074	-$10,746,801	-$5,842,080	-$17,341,305
Total	-$177,832,985	-$116,192,068	-$63,163,296	-$187,490,398
Percentage Difference				
County Share	-29.13%	-21.17%	-12.74%	-30.24%
Member Share	-29.13%	-21.17%	-12.74%	-30.24%
Total	-29.13%	-21.17%	-12.74%	-30.24%

Notes:
Part B Premiums:
Assumes all current members have the same Part B reimbursement as current levels either $94.60 or $110.50.

(1) Migration A:
PacifiCare and CIGNA Risk members move to the PacifiCare and CIGNA non-Risk HMOs
Kaiser Risk members move to the Kaiser Excess plan
Plan III and Scan members move to Plan II
County stops paying Part B premium for all members

(2) Migration B:
PacifiCare, CIGNA, Kaiser, and Scan members move to Plan II
Plan III members stay in Plan III
County continues to pay Part B premium for Plan III members

(3) Migration C:
PacifiCare, CIGNA, Kaiser, and Scan members move to Plan II and Plan III
Plan III members stay in Plan III
County continues to pay Part B premium for Plan III members

(4) Migration D:
PacifiCare, CIGNA, Kaiser, Scan and Plan III members move to Plan II
County stops paying Part B premium for all members

GRIST Report: CMS issues 2011 Medicare premium, deductible and coinsurance amounts

By Barbara McGeoch and Fran Bruno of Mercer's Washington Resource Group
Nov. 9, 2010

In This Article

Summary

The Centers for Medicare and Medicaid Services has announced the 2011 beneficiary premiums, deductibles and other cost-sharing amounts for Medicare Parts A and B. The standard Part B monthly premium will increase to $115.40 in 2011, up from $110.50 in 2010. However, many Medicare beneficiaries won't be affected by this increase because of a little-used provision of federal law. The announcement also includes special income-adjusted monthly Part B and Part D premiums for higher-income beneficiaries.

Medicare beneficiary cost-sharing requirements

Medicare beneficiaries are subject to various cost-sharing requirements, including monthly premiums, daily coinsurance amounts for certain benefits and annual deductibles. These amounts are adjusted annually based on Medicare rules. The Centers for Medicare and Medicaid Services (CMS) has released the 2011 amounts for Medicare Parts A and B, as well as the new Part D income-based premiums. (For prior years' amounts, see GRIST #20090252, Oct. 21, 2009.) Because Social Security benefits won't get a cost-of-living increase in 2011, many Medicare beneficiaries will pay the same Part B premium they paid in 2010.

Part A – Hospital insurance

Medicare Part A beneficiaries are subject to a deductible for inpatient hospital stays. If hospitalized more than 60 days, beneficiaries also must pay daily coinsurance, which varies depending on the duration of the stay. Beneficiaries who receive services in a skilled nursing facility are subject to separate daily coinsurance.

Although most individuals qualify for premium-free Part A coverage, those who haven't had enough quarters of Medicare covered employment must pay monthly premiums. The Part A premium depends on how many covered quarters a beneficiary has and whether Medicare enrollment is due to age (such as seniors age 65 and older) or disability. The table below shows the Part A deductibles, coinsurance amounts and premiums for 2010 and 2011. (For more detail

on how these amounts are calculated, see CMS's notices on the Part A premium and Part A deductible and coinsurance amounts.)

Part A – Hospital insurance		
Component	2011	2010
Hospital inpatient deductible	$1,132	$1,100
Hospital daily coinsurance		
▪ Days 61-90	283	275
▪ Lifetime reserve days	566	550
Skilled nursing facility daily coinsurance	141.50	137.50
Monthly premium		
▪ Seniors with fewer than 30 covered quarters and certain people with disabilities under 65	450	461
▪ Seniors with 30-39 covered quarters and people with disabilities who have 30 or more covered quarters	248	254

Part B – Medical insurance

Medicare beneficiaries with Part B coverage pay monthly premiums and an annual deductible. People in higher-income brackets pay higher premiums – on a graduated scale – depending on their annual income (GRIST #20060055, March 7, 2006).

No increase in Part B premium for many in 2011. Although the Medicare Part B standard premium will increase to $115.40 in 2011 (up from $110.50 in 2010), nearly three quarters of Medicare beneficiaries will pay the $96.40 premium in effect for 2008 and 2009. This group is primarily made up of individuals who already receive both Social Security and Medicare benefits, aren't subject to the Part B adjustment for higher-income beneficiaries, and have Part B premiums deducted from their monthly Social Security checks.

Obscure rule applies again in 2011. A special provision of the Medicare law prohibits year-to-year reductions in Social Security benefits caused solely by higher Part B premiums. Because Social Security benefits will not increase in 2011, beneficiaries who have Part B premiums deducted from their checks would see a reduced net benefit if the higher 2011 premium applied. So these beneficiaries won't have to pay the annual increase. The same situation excused most beneficiaries from paying higher 2010 Part B premiums and, because the 2009 Part B premium did not change from the 2008 level, many beneficiaries will continue to pay a $96.40 premium – as they have since 2008.

Medicare beneficiaries who don't fall into the above categories will pay increased 2011 Part B premiums. The table below lists the Part B deductibles and monthly premiums for 2010 and 2011, including the income-adjusted premiums for higher-income beneficiaries. (For details on how these amounts are calculated, see CMS's notice on the Part B premium and deductible.)

Part B – Medical insurance[1]					
2011			2010		
Annual income	Monthly premium	Annual deductible	Annual income	Monthly premium	Annual deductible
$0 ≤ $85,000[2]	$115.40[3]	$162.00	$0 ≤ $85,000[2]	$110.50	$155.00
> 85,000 ≤ 107,000	161.50		> 85,000 ≤ 107,000	154.70	
> 107,000 ≤ 160,000	230.70		> 107,000 ≤ 160,000	221.00	
> 160,000 ≤ 214,000	299.90		> 160,000 ≤ 214,000	287.30	
> 214,000	369.10		> 214,000	353.60	

[1] Table does not reflect income-adjusted premiums for individuals filing joint tax returns or for married individuals living with spouse at any time during the taxable year but filing separate returns.

[2] Income bracket for most unmarried beneficiaries filing individual returns

[3] This premium amount applies only to a limited number of beneficiaries due to a rarely applied Medicare law exempting many from a Part B premium increase in 2011.

Part D – Outpatient prescription drug coverage

As mandated by the health care reform law, the Part D program for outpatient prescription drugs will charge higher premiums to higher-income enrollees in 2011. The usual monthly premium is paid to the plan; the added amount (or "adjustment") for higher-income beneficiaries will be deducted from an enrollee's Social Security benefits and paid to Medicare. The table below lists the graduated monthly premium adjustments for different annual income tiers. (For 2011 Part D annual deductibles, out-of-pocket limits and other indexed figures announced last spring, see GRIST #20100091, April 19, 2010.)

Part D – Prescription drug coverage[1]			
2011		2010	
Annual income	Monthly premium adjustment		
$0 ≤ $85,000[2]	$0	Not applicable	
> 85,000 ≤ 107,000	12		
> 107,000 ≤ 160,000	31.10		
> 160,000 ≤ 214,000	50.10		
> 214,000	69.10		

[1] Table does not reflect income-based premium adjustments for individuals filing joint tax returns or for married individuals living with spouse at any time during the taxable year but filing separate returns.

[2] Income bracket for most unmarried beneficiaries filing individual returns

For more information, contact Mercer's Washington Resource Group at +1 202 263 3950.

WRG only: #20100284

ATTACHMENT III

KAISER MEDICARE AND NON-MEDICARE HEALTH PLAN RATE COMPARISON
(BASED ON JULY 1, 2010 TO JUNE 30, 2011 RATES)
RETIREE ONLY

		MEDICARE RISK HMO					HMO				
		KAISER SENIOR ADVANTAGE (Assigned both Parts A & B)					Kaiser Excess I (Assigned only Part A)				
	MAXIMUM COUNTY SUBSIDY FOR ALL PLANS	2011 MEDICARE PART B SUBSIDY	ACTUAL COUNTY SUBSIDY	TOTAL COUNTY COST	RETIREE COST	TOTAL INSURANCE PREMIUM	MEDICARE PART B SUBSIDY	ACTUAL COUNTY SUBSIDY	TOTAL COUNTY COST	RETIREE COST	TOTAL INSURANCE PREMIUM
10 YOS (40%)	$365.72	$115.40	$87.47	$202.87	$131.21	$218.68	$0.00	$334.64	$334.64	$501.96	$836.60
15 YOS (60%)	$548.57	$115.40	$131.21	$246.61	$87.47	$218.68	$0.00	$501.96	$501.96	$334.64	$836.60
20 YOS (80%)	$731.43	$115.40	$174.94	$290.34	$43.74	$218.68	$0.00	$669.28	$669.28	$167.32	$836.60
25 YOS (100%)	$914.29	$115.40	$218.68	$334.08	$0.00	$218.68	$0.00	$836.60	$836.60	$0.00	$836.60

ATTACHMENT IV

KAISER TWO-PARTY MEDICARE HEALTH PLAN RATE COMPARISON
(BASED ON JULY 1, 2010 TO JUNE 30, 2011 RATES)
RETIREE AND SPOUSE *

		KAISER SENIOR ADVANTAGE (Retiree & Spouse Assigned both Parts A & B)					Kaiser Excess I (Retiree & Spouse Assigned only Part A)				
	MAXIMUM COUNTY SUBSIDY FOR ALL PLANS	2011 MEDICARE PART B SUBSIDY	ACTUAL COUNTY SUBSIDY	TOTAL COUNTY COST	RETIREE COST	TOTAL INSURANCE PREMIUM	MEDICARE PART B SUBSIDY	ACTUAL COUNTY SUBSIDY	TOTAL COUNTY COST	RETIREE COST	TOTAL INSURANCE PREMIUM
10 YOS (40%)	$660.04	$230.80	$173.74	$404.54	$260.62	$434.36	$0.00	$668.08	$668.08	$1,002.12	$1,670.20
15 YOS (60%)	$990.05	$230.80	$260.62	$491.42	$173.74	$434.36	$0.00	$1,002.12	$1,002.12	$668.08	$1,670.20
20 YOS (80%)	$1,320.07	$230.80	$347.49	$578.29	$86.87	$434.36	$0.00	$1,336.16	$1,336.16	$334.04	$1,670.20
25 YOS (100%)	$1,650.09	$230.80	$434.36	$665.16	$0.00	$434.36	$0.00	$1,670.20	$1,670.20	$0.00	$1,670.20

* Based on Anthem Blue Cross I and II subsidy cap applicable to family coverage. Indicated Kaiser costs apply to retiree and one or more dependents.

ATTACHMENT V

ANTHEM BLUE CROSS MEDICARE AND NON-MEDICARE HEALTH PLAN RATE COMPARISON
(BASED ON JULY 1, 2010 TO JUNE 30, 2011 RATES)
RETIREE ONLY

		MEDICARE SUPPLEMENT					INDEMNITY PLAN							
		ANTHEM BLUE CROSS III (Assigned both Parts A & B)					ANTHEM BLUE CROSS I (MEDICARE NOT REQUIRED)				ANTHEM BLUE CROSS II (MEDICARE NOT REQUIRED)			
	MAXIMUM COUNTY SUBSIDY FOR ALL PLANS	2011 MEDICARE PART B SUBSIDY	ACTUAL COUNTY SUBSIDY	TOTAL COUNTY COST	RETIREE COST	TOTAL INSURANCE PREMIUM	ACTUAL COUNTY SUBSIDY	TOTAL COUNTY COST	RETIREE COST	TOTAL INSURANCE PREMIUM	ACTUAL COUNTY SUBSIDY	TOTAL COUNTY COST	RETIREE COST	TOTAL INSURANCE PREMIUM
10 YOS (40%)	$365.72	$115.40	$118.71	$234.11	$178.07	$296.78	$365.72	$365.72	$548.57	$914.29	$365.72	$365.72	$548.57	$914.29
15 YOS (60%)	$548.57	$115.40	$178.07	$293.47	$118.71	$296.78	$548.57	$548.57	$365.72	$914.29	$548.57	$548.57	$365.72	$914.29
20 YOS (80%)	$731.43	$115.40	$237.42	$352.82	$59.36	$296.78	$731.43	$731.43	$182.86	$914.29	$731.43	$731.43	$182.86	$914.29
25 YOS (100%)	$914.29	$115.40	$296.78	$412.18	$0.00	$296.78	$914.29	$914.29	$0.00	$914.29	$914.29	$914.29	$0.00	$914.29

ATTACHMENT VI

ANTHEM BLUE CROSS TWO-PARTY MEDICARE HEALTH PLAN RATE COMPARISON
(BASED ON JULY 1, 2010 TO JUNE 30, 2011 RATES)
RETIREE AND SPOUSE

		ANTHEM BLUE CROSS III (Retiree & Spouse Assigned both Parts A & B)					ANTHEM BLUE CROSS I OR II (MEDICARE NOT REQUIRED)				
	MAXIMUM COUNTY SUBSIDY FOR ALL PLANS	2011 MEDICARE PART B SUBSIDY	ACTUAL COUNTY SUBSIDY	TOTAL COUNTY COST	RETIREE COST	TOTAL INSURANCE PREMIUM	MEDICARE PART B SUBSIDY	ACTUAL COUNTY SUBSIDY	TOTAL COUNTY COST	RETIREE COST	TOTAL INSURANCE PREMIUM
10 YOS (40%)	$660.04	$230.80	$236.69	$467.49	$355.04	$591.73	$0.00	$660.04	$660.04	$990.05	$1,650.09
15 YOS (60%)	$990.05	$230.80	$355.04	$585.84	$236.69	$591.73	$0.00	$990.05	$990.05	$660.04	$1,650.09
20 YOS (80%)	$1,320.07	$230.80	$473.38	$704.18	$118.35	$591.73	$0.00	$1,320.07	$1,320.07	$330.02	$1,650.09
25 YOS (100%)	$1,650.09	$230.80	$591.73	$822.53	$0.00	$591.73	$0.00	$1,650.09	$1,650.09	$0.00	$1,650.09

ATTACHMENT VII

KAISER MEDICARE AND NON-MEDICARE HEALTH PLAN BENEFITS COMPARISON

	MEDICARE RISK HMO	
	Kaiser Senior Advantage **(Assigned both Parts A & B)**	Kaiser Excess I **(Assigned only Part A)**
Expenses		
Calendar Year Deductibles	None	
Annual Maximum Out-of-Pocket Expenses	Max Co-payments of: $1,500 – Individual $3,000 - Family	
Lifetime Maximum Benefits	Unlimited	
Hospital Benefits		
Room and Board	No charge	
Surgical Services	No charge	No charge for inpatient; $5 copay for outpatient
Hospital Services and Supplies	No charge	
Emergency Benefits		
Inpatient	$5 copay; waived if admitted	No charge
Outpatient	$5 copay; waived if admitted	
Ambulance	No charge for emergency	
Outpatient Benefits		
Doctor's Office Visit	$5 copay	
Preadmission x-ray and lab tests	No charge	
Routine checkups	$5 copay	
Immunizations	No charge	
Outpatient Surgical services	$5 copay per procedure	
Physical Therapy	$5 copay	
Speech Therapy	$5 copay	
Prescription Drugs	$7 copay for up to 100-day supply, covers dental prescriptions	
Vision/Hearing Care Benefits		
Eye Exams	$5 copay	
Lenses	Eyewear purchased from plan optical sales offices every 24 months; $150 allowance	Not covered
Frames	Eyewear purchased from plan optical sales offices every 24 months; $150 allowance	Not covered
Hearing Exams	$5 copay	
Hearing Aids	Not covered	
Durable Medical Equipment	**Covered**	**Not covered**

ATTACHMENT VIII

BLUE CROSS MEDICARE AND NON-MEDICARE HEALTH PLAN BENEFITS COMPARISON

	MEDICARE SUPPLEMENT	INDEMNITY PLAN	
	ANTHEM BLUE CROSS III **(Assigned both Parts A & B)**	ANTHEM BLUE CROSS I **(Medicare not required)**	ANTHEM BLUE CROSS II **(Medicare not required)**
Expenses			
Calendar Year Deductibles	None	$100 individual, $100 family	$500 individual; $1,500 family
Annual Maximum Out-of-Pocket Expenses	None	N/A	$2,500 including deductible
Lifetime Maximum Benefits	Unlimited	$1,000,000	$1,000,000
Hospital Benefits			
Room and Board	Plan pays all Medicare inpatient deductibles for approved Medicare days	$75/day $150/day special care unit	90% PPO hospital; 80% non-PPO
Surgical Services	Plan pays all Medicare inpatient deductibles for approved Medicare days	According to schedule + 80% of balance	80%
Hospital Services and Supplies	Plan pays all Medicare inpatient deductibles for approved Medicare days	100%	90% PPO hospital; 80% non-PPO hospital
Emergency Benefits			
Inpatient	Plan pays all Medicare inpatient deductibles for approved Medicare days	$75/day $150/day special care unit	90% PPO hospital; 80% non-PPO hospital
Outpatient	20% of Medicare approved charges	100% at a hospital only	80%
Ambulance	20% of Medicare approved charges	80% for transportation to first hospital where care is given	80% for transportation to first hospital where care is given
Durable Medical Equipment	Covered	80% for covered, medically necessary medical equipment after deductible met	80% for covered, medically necessary medical equipment after deductible met

ATTACHMENT VIII (Continued)

BLUE CROSS MEDICARE AND NON-MEDICARE HEALTH PLAN BENEFITS COMPARISON

	MEDICARE SUPPLEMENT	INDEMNITY PLAN	
	ANTHEM BLUE CROSS III **(Assigned both Parts A & B)**	ANTHEM BLUE CROSS I **(Medicare not required)**	ANTHEM BLUE CROSS II **(Medicare not required)**
Outpatient Benefits			
Doctor's Office Visit	20% of Medicare approved charges	80%	
Preadmission x-ray and lab tests	20% of Medicare approved charges	100%	
Routine checkups	Not covered except for dependent children under age 17	$25 copay; covered in-network only; maximum $250	$25 copay; covered in-network only; maximum $250
Immunizations	Not covered except for dependent children under age 17	Not covered except for dependent children under age 17	
Outpatient Surgical services	20% of Medicare approved charges	100%	100% (80% hospital facility fees)
Physical Therapy	20% of Medicare approved charges	80% in accordance with requirements	
Speech Therapy	20% of Medicare approved charges	80% in accordance with requirements	
Prescription Drugs	80% in-network, 60% out-of-network; $10 generic/$30 brand/$50 non-preferred brand/$150 specialty copay for mail order for 90-day supply		
Vision/Hearing Care Benefits			
Eye Exams	Not covered	Covered after accident only	
Lenses	Not covered unless 1st lens after eye surgery	Covered after accident and after eye surgery	
Frames	Not covered unless after eye surgery	Covered after accident or after eye surgery only	
Hearing Exams	One per year; 80%	Covered after accident only	
Hearing Aids	50% up to $300 lifetime maximum	Covered after accident only	